

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-045813

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

11127

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

FILED NOV 22 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN St. LouisLength of stay in lb
8 Yrs.c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION 2631 S. 7th St.Inside Limits
Yes ☒ No ☐2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY

c. CITY OR TOWN St. Louis

Inside Limits
Yes ☒ No ☐d. STREET ADDRESS (If outside, give location)
2631 S. 7th St.Reside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First MYRTLE

Middle

Last MILLER

4. DATE OF DEATH

Month 11

Day 10

Year 63

5. SEX

Female

6. COLOR OR RACE

White

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

3/3/14

9. AGE (last birthday)

49

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife10b. KIND OF BUSINESS OR INDUSTRY
Own Home11. BIRTHPLACE (City and state or country)
Tennessee12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME

Andrew Horton

13b. MOTHER'S MAIDEN NAME

Ada Hargraves

14. NAME OF HUSBAND OR WIFE

Robert

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Robert Miller, 2631 S. 7th

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Generalized Carcinomatosis

INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b)

Cancer of Uterus

Nov 1962

DUE TO (c)

174X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from March 3, 1963 to Nov 10, 1963 and last saw her alive on Nov 9, 1963
Death occurred at 1:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Leroy E. Ellison M.D.

22b. ADDRESS

3610 80 Broadway, St Louis Mo 11-10-63

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal

23b. DATE

11/11/63

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

Louisville, Kentucky

(State)

24. FUNERAL DIRECTOR

ADDRESS

McLAUGHLIN'S, 2301 Lafayette

25. DATE RECD. BY LOCAL REG.

NOV 12 1963

26. REGISTRAR'S SIGNATURE

Earl Smith, M.D.

USE BLACK INK
OR
TYPEWRITER RIBBON

111110-001

10111

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

H. J. Ferris

Licensed Embalmer No. 3384

P. O. Address

St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.